



Washington, D.C. May 22-24, 2024

Medication Administration Record (MAR) **ONE medication per form**

Student Information

Student Name		DOB
School	Year	
Known Allergies	Height	Weight

Prescriber Information

Name of Medication ONE PER FORM		Reason for Use	
Dosage	Route	Frequency	
Special Instructions			
Prescriber Signature			Phone
Prescriber Name (print)		Date	Fax

Licensed Health Provider Sign

Parent/Guardian Authorization

I authorize an employee of the school board to administer the above medication. I authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

Medication form must be received by the principal, designee, and/or the school nurse. I understand the medication must be in the original container and be properly labeled with the student's name, name of medication, dosage, and strength.

Parent/Guardian Signature	Date	#1 Contact Phone	#2 Contact Phone
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Parent Sign

Parent/Guardian Self-Carry Authorization (if applicable)

For Epinephrine Auto Injector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine auto injector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

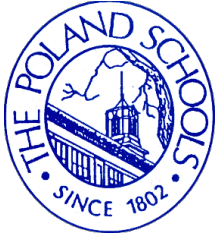
For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent/Guardian Signature	Date	#1 Contact Phone	#2 Contact Phone
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*****STAFF USE ONLY Medication Documentation Record (MDR) STAFF USE ONLY*****

Month	May		
Day	22nd	23rd	24th
Time given and initials			

Nurse/Staff Signature _____ Initials _____



Poland Seminary Junior Senior High School

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Medication Administration Guidelines

These are the guidelines for medication administration in the Poland schools as reflective of Board Policy 5330 & Ohio Revised Code 3313.

- **ALL MEDICATION** must be delivered to the school by a parent/guardian in the **original container** labeled with the student's name. Medications that are not in the original container **WILL NOT BE ACCEPTED.**
- **ALL MEDICATION, BOTH prescription and over-the-counter** must be accompanied by a medication form that has been signed by **BOTH Licensed Health Care Provider** (Doctor-MD/DO, dentist, orthodontist, CNP, or PA), **AND** the parent/guardian.

Forms are available on the school website or in the school clinic.

Only ONE medication can be listed per form.

Medication forms are VALID ONLY for the current school year.

- Students are **not permitted to carry ANY** medications in school, unless it is an Epinephrine auto-injector or rescue inhaler (a signed medication form must be on file in the school clinic).

ANY QUESTIONS OR CONCERNS PLEASE CALL:

Holly Lefoer: PSJSHS (330)757-7018,#6, or extension 37334
School Nurse